Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Unified Health Services

Respondent Name
Deep East Texas Self Insurance

MFDR Tracking Number
M4-14-3001-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
June 2, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: **"**This denial has been denied in error, as CPT 97140 is a payable service for this DOS."

Amount in Dispute: 46.41

Respondent's Position Summary: "Based on the submitted documentation no additional recommendation is being made at this time."

Response Submitted by: Injury Management Organization ,Inc 10235 West Little York Road, Suite 265, Houston, TX 77040

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
October 16, 2013	Outpatient Physical Therapy	$46.41	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the fee guidelines for outpatient acute care hospital services.
3. 28 Texas Administrative Code §134.600 sets out the fee guidelines for prospective and concurrent review of health care.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 197 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 197 – Precertification/authorization/notification absent
   - 193 – Original payment decision is being maintained

Issues

1. Was the disputed service prior authorized?

2. Is the requestor entitled to reimbursement?

Findings

1. The service in dispute was denied as, 197 – "Precertification/authorization/notification absent". Review of the submitted documentation finds;

    a. Preauthorization Determination Letter dated 10/1/2013 did not authorize CPT code 97140 for any dates of service.

    28 Texas Administrative Code 134.600(p) Non-emergency health care requiring preauthorization includes:(5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels: (A) Level I code range for Physical Medicine and Rehabilitation, but limited to: (i) Modalities, both supervised and constant attendance; (ii) Therapeutic procedures, excluding work hardening and work conditioning." The carrier's denial is supported.

2. Requirements of Division Rule were not met. No payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		September , 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.